A STUDY OF INSTRUMENTAL PERFORMANCE LEVELS OF FORMER MENTAL PATIENTS IN RELATION TO PERCEIVED EXPECTATIONS OF SIGNIFICANT OTHERS

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A STUDY OF INSTRUMENTAL PERFORMANCE LEVELS OF FORMER MENTAL PATIENTS IN RELATION TO PERCEIVED EXPECTATIONS OF SIGNIFICANT OTHERS

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PREFACE

There is increasing concern in the field of mental health with rehabilitating the former mental patient in order that he might become a functioning member of his community. The purpose of this study is to determine whether there is a relationship between the attitudinal components and expectations of significant others of former mental patients and the performance level, occupationally and socially, of ex-patients from a state hospital.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Statement of the Problem

During the past decade, profound changes have been occurring in the treatment of psychotic patients. Medical science has learned to control many of the more troublesome overt symptoms of mental illness which has meant earlier discharge from the hospital for many mental patients.[1] The length of stay in the mental hospital has declined and fewer hospital beds are needed, but readmission rates have increased.[2] The major problem of rehabilitation has, therefore, been transferred from the hospital to the community. Thus, those interested in rehabilitating the mental patient are giving increasing attention to the situations within the community to which the mental patient returns upon release from the hospital.[3] Rehabilitation of the patient in the community is the primary concern. Rehabilitation has been defined by the National Council on Rehabilitation as, "...the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic

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[1]E. Harrison, Mental Aftercare: Assignment for the Sixties (Public Affairs Pamphlet No. 318, September, 1961), p. 4.

[2]Howard E. Freeman and Ozzie G. Simmons, The Mental Patient Comes Home (New York and London, 1963), p. 2.

[3]E. Harrison, Chapter 1.

usefulness of which they are capable."[4] Similarly, Dr. Maxwell Jones defines rehabilitation as, "the attempt to provide the best possible community role which will enable the patient to achieve the maximum range of activities compatible with his personality and interest, and of which he is capable."[5]

The concern in rehabilitation, therefore, is with the patient himself as he is restored to adequate functioning within his position in the family and community. The adequate functioning of the ex-patient is an observable phenomenon, measured in terms of his actions in his various statuses in relation to the role expectations associated with these statuses. Rehabilitation, according to this definition, is within the theoretical framework of action. The interest is directed to the question of how the ex-patient acts in social situations. The situations to which he returns from the mental hospital and in which he must function according to the norms of society include those found in the family, occupation, and social participation in the community. More specifically, then, this research is concerned with the performance of the ex-mental patient in these various situations.

The meaning of a situation is not just automatically determined by one's participation in it. There must first be some definition of one's surroundings in a meaningful manner before there can be action with respect to the situation. Therefore, as an ex-patient approaches any particular situation he must define it in a meaningful manner before he

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[4]Thomas A. C. Rennie, "The Rehabilitation of the Mentally Ill," The Elements of a Community Mental Health Program (New York, 1956), p. 187.

[5]Ibid., p. 187.

can act. One of the crucial aspects of every situation which the ex-patient must define for himself is the role expectations others hold for him. His definition of these expectations will be related to the subsequent action he takes. In this thesis a direct relationship is hypothesized between the performance level of the ex-patient and his definition of the expectations of significant others. This is based on the assumption that congruence between expectations and performance is essential to the stability of any interpersonal system. It is expected, for example, that returning a patient to a situation characterized by high expectations for his occupational and social performance may result in better functioning in these situations; while a situation characterized by low expectations may result in a regression from, rather than movement toward, better functioning. This hypothesis challenges the view in mental health research that high expectations for the returning mental patient may cause withdrawal and thus lower performance.[6] In view of the lack of clear empirical evidence regarding the importance of perceived expectations, this research studies the relationship between role expectations of significant others as perceived by the former mental patient and his instrumental performance level.

Review of the Literature

This review is primarily concerned with the literature which deals with problems of rehabilitation of former mental patients in the community. Because sixty to seventy per cent of the patients in mental

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[6] See A. Green, "The Middle-Class Male Child and Neurosis," American Sociological Review 51 (February, 1946), pp. 31-41; Edwin Lemert, Social Pathology (New York, 1951); and Richard T. LaPiere, A Theory of Social Control (New York, 1954).

hospitals are patients who have been hospitalized before, more knowledge is needed on what might be done to enable the mental patient who has been released to remain as an adequately functioning member of his community.[7] The basic research problem is to determine what variables account for variations in readmission rates. There are several different views reported in the literature, but they all agree that it is becoming increasingly important to study the situations to which the patient returns. Clausen feels, for example, that few, if any, research topics have higher priority among psychiatric research workers and none poses more complexities than the evaluation of therapy. One reason for this is the lack of adequate data on the natural history of psychiatric disorders in various social milieux. A well-designed study in this area, according to Clausen needs to know something, at least, of the nature of the social system to which the patient is returning, and the role patterns that he carries out upon his return home.[8]

There is a widely held view which has been expressed by both professional and lay writers that the adjustment of ex-mental patients is facilitated by acceptance of family members of a high degree of deviance from traditional role performance expectations and low expectations regarding instrumental performance (work, family, social participation). It is felt that having high expectations of former mental patients tends to endanger adequate adjustment, and families have been encouraged to establish maximum ranges of tolerance with regard to deviant behavior. Thus, the emphasis has been upon continued acceptance of the former

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[7] E. Harrison, p. 4.

[8] John A. Clausen, Sociology and the Field of Mental Health (New York, 1956), p. 38.

patient, even when he has failed to perform adequately in instrumental roles.[9]

A direct relationship was hypothesized by Freeman and Simmons between the performance level of the patient and the expectations of family members. This hypothesis is based on the assumption that congruence between expectations and performance is essential to the stability of an interpersonal system; that is, low-level performance on the part of the patient must be complemented by low expectations on the part of his relative for him to remain in the family. The primary reason why Freeman and Simmons investigated this relationship was to provide support for their proposition that the tolerance shown by family members is of strategic importance for the posthospital fate of the patient.[10] Their findings suggested that family milieux characterized by high expectations, and in which there were no other actors available to occupy or share the occupancy of roles normatively prescribed for the adult male, are more likely to encourage movement toward high performance.[11] It was hypothesized that if there is congruence between performance levels of patients and expectations of relatives, then variables identified as correlates of the former should also be associated with the latter. There is an association between the expectations of the relatives and their kin relationship to the patients. For example, relatives of patients whose familial role is that of son tend to have lower expectations regarding posthospital performance than do relatives

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[9]See A. Green, pp. 31-41.

[10]Ozzie G. Simmons and Howard E. Freeman, "Familial Expectations and Post-Hospital Performance of Mental Patients," Human Relations 12 (August, 1959), p. 235.

[11]Ibid., p. 241.

of patients whose familial role is husband.[12] The argument is that the differential demands and expectations of family members in different family settings constitute the key variables in the posthospital performance of patients.[13]

In Freeman and Simmon's study, rehabilitation was conceived in absolute terms and with respect to only two stages; namely, that of successful community tenure and of instrumental role performance during the patient's stay in the community. The two stages of rehabilitation with which they were concerned included one in which the patient is able to succeed in remaining in the community and a second in which he is able not only to stay in the community but to attain as well a level of occupational and social functioning comparable to that of most other adult members of the community.[14] Their findings suggest that the difference between successful and unsuccessful patients are more marked in the realm of affective components of behavior than in the realm of instrumental role performance.[15] Freeman and Simmons are convinced, "that it is the differential quality of the role relationships which is critical to understanding the influence of significant others in the posthospital experience of the patient."[16] For example, with respect to the role of the patient in the family, there is the question of the

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[12]Ibid., p. 237.

[13]Freeman and Simmons, The Mental Patient Comes Home, p. 101.

[14]Ibid., p. 37.

[15]Ibid., pp. 66, 67.

[16]Howard E. Freeman and Ozzie G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," American Sociological Review 23 (April, 1958), p. 154.

availability of functionally equivalent actors to occupy the normally prescribed roles. "Our normative judgment of whether occupational and social performance is high or low is based solely on the quantity and stability of performance of instrumental roles."[17] The more relevant findings in this study indicated that there is a wide range of variation in performance levels among patients who can leave the hospital and remain for extended periods in the community. Social participation of the patients in the study group, for example, ranged from being highly active in formal and informal social relationships to being as isolated and inactive as hospitalized patients in chronic wards.[18]

While it may be effective in freeing a hospital bed, releasing a patient to the tolerant milieu which tends to predominate in the parental family may be the most inadequate community setting if movement toward instrumental performance is a desired outcome of hospitalization. Returning the patient to the parental family where there is likely to be low expectations of instrumental performance, may well occasion regression from, rather than movement toward, better functioning, and eliminate any gains of a therapeutic hospital experience.[19]

The variables that were derived from Freeman and Simmon's proposition of tolerance of deviance reflect the extent to which the role expectations of significant others account for the level of instrumental performance. In the very simplest terms, one can say that persons do what their relatives expect them to do, that spouses have higher

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[17]Freeman and Simmons, The Mental Patient Comes Home, p. 38.

[18]Ibid., p. 5.

[19]Freeman and Simmons, "Mental Patients in the Community," p. 154.

expectations than parents, and that the differential performance levels represent the adaptation of the patients to the expectations of their family members.[20] The findings of their study suggest that illness behavior is primarily referable to intrapsychic and possibly organic factors, and instrumental performance to interpersonal and social factors.[21] In the framework of rehabilitation it was found that while performance levels were associated with social factors, there was virtually no evidence that success or failure to remain in the community was associated with such factors.[22]

Dinitz, et. al., have investigated a population of female former mental patients. Trained and experienced psychiatric social workers studied intensively a population of 287 female patients discharged from the Columbus Psychiatric Institute and Hospital in the period December 1, 1958 through July 31, 1959. This research was investigating the functioning of patients after release from the hospital within the framework of the influence of social factors. These researchers quote Freeman and Simmons as suggesting that psychiatric and other medical aspects are less important in determining the readjustment of the mental patient then are the attitudes of relatives to whom the patient is returning. They noted that George W. Brown, in his study in London, found that the type of living arrangement to which patients return is

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[20]Freeman and Simmons, The Mental Patient Comes Home, p. 99.

[21]Ibid., p. 160.

[22]Ibid., p. 177.

the most significant factor in their success or failure.[23] In measuring the level of patient functioning after discharge the researchers interviewed both the former patient and a significant other, usually the closest relative. The quality of posthospital patient performance was derived from responses to three scales in the interview schedules of the significant other. These included a measurement of psychological functioning, a measurement of domestic functioning dealing with the patient's performance of routine duties customarily associated with the female role and social participation.[24] Because of the relative homogeneity of the female patient population, the differences were slight in age, race, religion or rural-urban residence of the patients. Patients in all performance levels were approximately 40 years of age, predominantly white (87 per cent), Protestant (81 per cent) and urban (83 per cent). According to Dinitz there is little doubt that hospital diagnosis is of importance in predicting outcome. Medical or psychiatric variables, however, with the exception of diagnosis, are at best only very poor predictors of outcome. The results of their research indicate that a much stronger case can be made for the relation of objective social variables and outcome.[25] Marital status and living arrangements were found to be very highly related to posthospital functioning. Married patients were found to be under-represented among the

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[23]Simon Dinitz, Mark Lefton, Shirley Angrist and Benjamin Pasamanick, "Psychiatric and Social Attributes as Predictors of Case Outcome in Mental Hospitalization," Social Problems 8 (Spring, 1961), pp. 322-323.

[24]Ibid., p. 323.

[25]Ibid., p. 326.

low performers and over-represented among the high performers. Less than half of the low performers, three-fifths of the moderate performers and four-fifths of the high performers were married. Of the patients who returned to their parents a great many (41.7 per cent) were low performers. Of those who returned to their spouses, far fewer (21.4 per cent) were poor performers. According to these findings, not only will patients returned to a conjugal family perform better, but those returning to households devoid of other adults able to do the job will be even better. Again, it could be argued that patients do better when role replacements are not available. Other variables indicative of performance level were social class and education. Good posthospital performance appeared to be related to relatively high educational attainment and socioeconomic status. The contrast between the college educated and those with only a grade school education was pronounced. Low performers were also observed to be drawn from the lower socio-economic segments of the former patients; high performers from the highest socioeconomic status segments.[26]

The research of Dinitz, et. al., lends additional evidence to the proposition that the posthospital family milieu is a fairly accurate predictor of the performance levels of the ex-patient. Familial variables seem to be extremely significant when the degree of illness is controlled. The dynamics underlying the success of patients returning to the conjugal setting are assumed by Dinitz to be largely subjective (attitudinal) in nature. The significant others of patients in these households are likely to have high expectations for performance and are

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[26]Ibid., p. 327.

unlikely to be very tolerant of deviant behavior in the patient, the former patients themselves are also likely to expect more of themselves and greater external demands are likely to impinge upon them. These greater pressures for success and for the fulfillment of the prerequisites of the female role are likely, therefore, to be translated into better posthospital performance.[27]

Leta M. Adler has also hypothesized that married life makes for low incidence of mental illness and high probability of recovery. The variables in married life which were supposed to be indicative of higher probability of recovery were not those relating to higher expectation levels but rather the emotional security and social stability afforded to the married person. There are several questions that should be raised concerning this hypothesis. One is that differences observed might be due to age differences between persons of different marital statuses. Another question that remains unanswered is whether or not observed differences might result from the effects of mental illness on the marital status of mentally ill persons before they are admitted to a mental hospital. In Adler's research there was not a statistically significant relation between the recovery level and marital status of ex-patients at the time of release from the hospital.[28]

In summarizing the results of the research it is evident that the type of living arrangement to which the former mental patient returns

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[27] Ibid., p. 328.

[28] Leta M. Adler, "The Relationship of Marital Status to Incidence of and Recovery from Mental Illness," Social Forces 32 (December, 1953), p. 194.

is regarded as of upmost importance in its influence on his adjustment. The variables which are observed as directly influencing posthospital adjustment are attitudinal factors and expectation levels. The basic conclusion which can be derived from previous research is that the higher the role expectations of significant others, the higher will be the level of instrumental performance.

On the basis of this review of published research which has investigated the influence of social factors on posthospital adjustment, the following postulates have been developed as a foundation for the present study:

(a) The instrumental role performance of former mental patients is a measure of adequate rehabilitation.

(b) The situations which are of most importance in measuring instrumental role performance are the world of work, whether in an occupation or at home, and social participation in the community.

(c) Whether occupational and social performance is judged high or low is based on the quantity rather than the quality of performance in these instrumental roles.

(d) Instrumental performance is primarily a result of interpersonal and social factors rather than intrapsychic and/or organic factors.

(e) Variations in instrumental role performance are directly influenced by the attitudinal components and expectation levels of significant others.

(f) Feelings of rejection and stigma are significant attitudinal components in the ex-patient's environment.

(g) The expectation levels of the relatives differ according to their kin relationship to the patients.

(h) Patients who are married and return to a conjugal setting will perceive higher expectations than those who are single and return to a parental setting.

(i) Patients returning to households where role-replacements are unavailable will perceive higher expectations than where customary roles are being performed by another family member.

In summary, there is a serious need for additional research which will assess the needs of returning mental patients and their families and help to identify those variables that influence the patient's successful readjustment to normal social roles.[29] This research attempts to study the variables relating to role expectations as the ex-patient perceives them in terms of expectations and insistence by family members on performance and in terms of perceived rejection and stigma by the community.

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[29]Clausen, pp. 34-35.

CHAPTER II

RESEARCH DESIGN AND METHODOLOGY

Introduction

The two major hypotheses which were tested in the present study are as follows:

(a) The structural characteristics of a former mental patient's family influences his instrumental performance level.

(b) The attitudinal characteristics of significant others influences the ex-patient's instrumental performance level.

The structural characteristics were measured by the type of family setting to which the ex-patient returns, his or her marital status and the number of full-time workers in the household other than the ex-patient. The attitudinal characteristics of significant others were measured by the ex-patient's perception of family expectations and insistence on performance and by his perception of rejection and stigma.

The primary objective in testing these hypotheses was to examine certain variables in the social environment of the former mental patient which might influence his posthospital adjustment. This research problem was developed out of a larger project which was initiated by the Oklahoma Department of Mental Health to evaluate the effects of an after-care program in which community and psychiatric services might be coordinated. It was the hope of this program that,

through coordination of existing community resources, more adequate services might be provided to assist the patient in making a more complete reintegration into community living. The research design for this study, developed after several meetings with the coordinator of the Community Service Project, involved three basic steps: (1) social analysis of areas in Tulsa with highest concentration of ex-mental patients released from the state hospital at Vinita, (2) development of an interview schedule which would adequately investigate pertinent social factors, and (3) selection of a sample population within the areas.[1]

There were several assumptions which had to be made because of the nature of the study, sample limitations, and time limits imposed by the sponsoring agency. It was assumed that the ex-patients were all in a similar state of mental health and able to perceive family expectations realistically. It was also assumed that every family shared essentially the same normative value system in expecting certain levels of performance of the ex-patient. This is important, for example, in view of the fact that previous research has found important value differences in community participation between social classes and educational levels.[2] It was also assumed that each patient had the same opportunity to reach certain levels of performance occupationally and socially.

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[1] Barry A. Kinsey, Integration of Ex-Mental Patients into the Community: A Social Survey of Selected Areas of Tulsa (Research Foundation, Oklahoma State University, November, 1964), p. 5.

[2] Howard E. Freeman and Ozzie G. Simmons, The Mental Patient Comes Home (New York and London, 1963), pp. 121-131; August B. Hollingshead and Fredrick C. Redlich, Social Class and Mental Illness (New York, 1958); Simon Dinitz, Mark Lefton, Shirley Angrist and Benjamin Pasamanick, "Psychiatric and Social Attributes as Predictors of Case Outcome in Mental Hospitalization," Social Problems 8 (Spring, 1961), p. 327.

Selection of the Sample

The selection of a sample for this study proved to be a very difficult task, primarily because a large percentage of the ex-patients could not be reached for an interview. The original plan called for a survey of at least one hundred patients released during the period of January, 1961, to August, 1963, residing in selected areas of Tulsa. Records from Eastern State Hospital and the Tulsa Mental Health Association were checked and all ex-patients with home addresses within any of the five selected areas were included in the original list of patients to be interviewed. In order to locate areas of highest patient concentration, all patients returning to the Tulsa community during the period of February, 1961, through June, 1964, were plotted on a map of the Tulsa Metropolitan Area. From this map, areas of highest patient population were designated and were based then upon census tract boundaries (see Figure 1). This analysis was intended not only to provide the basis for selection of a sample, but it also provided a more adequate understanding of those areas of the community within which the largest percentage of former mental patients are located. Through this process a group of ninety-five ex-patients was obtained which, according to records, resided in these sample areas. The breakdown of these cases is presented in Table I and, as the figures of Table I suggest, it was not possible to obtain a sufficient sample from this original group.[3]

A second list of ex-patients was obtained from the Department of Mental Health which consisted of patients released from Eastern State

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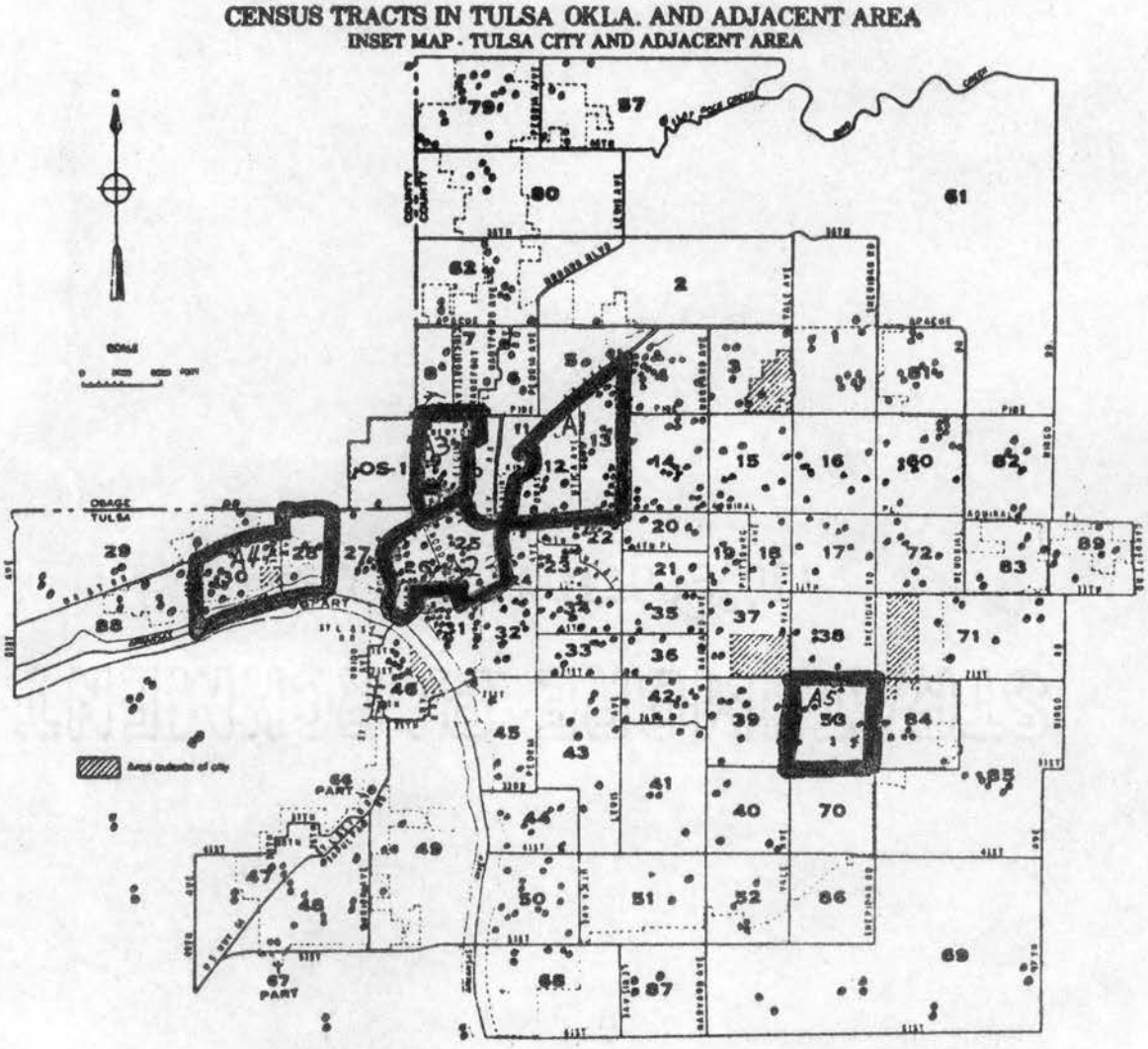
[3]Kinsey, p. 8.



A-1-Tracks Area
A-2-Downtown Area
A-3-Country Club Area
A-4-Sand Springs Area
A-5-Suburb Area

Figure 1. Areas with High Concentration of Ex-Patients from Eastern State Hospital, Vinita, Oklahoma.

TABLE I

DISPOSITION OF CASES SELECTED FROM FIVE AREAS OF HIGHEST CONCENTRATION OF EX-PATIENTS FROM EASTERN STATE HOSPITAL

Disposition of Cases	Number	Percent
Interviewed	24	25.3
Back in Hospital	14	14.7
Unable to Locate	19	20.0
Out of Tulsa Area	20	21.0
Deceased	2	2.1
Refused to be Interviewed	16	16.8
Total Number	95	100.0

Hospital on convalescent leave during April-May, 1964, July-August, 1963, and March-May, 1963. In some cases, this included patients who were not in the original areas but in adjacent areas with similar socio-economic characteristics. A summary of all the cases in the total sample is presented in Table II. Many attempts were made to locate all the patients in both groups. Often, patients had to be traced to several different addresses before some contact could be established. Where ex-patients or responsible relatives could not be located either by phone or by visiting their last known address--often repeated visits were necessary--efforts were made to trace them through neighbors, friends, employers, or others who might have had some contact with the respondent. Where these efforts failed, the names and last known addresses of respondents were checked against the records in Public Welfare (Tulsa Office), the Tulsa Council of Social Agencies, and Vocational Rehabilitation. Despite these detailed and time-consuming

TABLE II

DISPOSITION OF CASES IN TOTAL SAMPLE
OF EX-PATIENTS FROM TULSA

Disposition of Cases	Number	Percent
Interviewed	50	32.0
Back in Hospital	23	14.7
Unable to Locate	30	19.2
Out of Tulsa Area	29	18.6
Deceased	4	2.6
Refused to be Interviewed	20	12.8
Total Number	156	100.0

attempts to contact all ex-patients on both the original and final list, over two-thirds of the respondents could not be interviewed. More than half (57.9 per cent of the original list and 55.1 per cent of the total) could not be located because they were deceased, back in the hospital, out of the Tulsa Metropolitan Area, or simply could not be contacted. It should be emphasized, therefore, that the sample used in this study may be seriously biased in the direction of the more stable (at least residentially) members of the ex-patient population. There is also inadequate control for psychiatric variables. Included in the sample were those with organic and non-organic disorders and two who were known to be mentally retarded. Age of respondents ranged from fifteen to seventy-three, and the socioeconomic levels varied somewhat although most were concentrated in lower socioeconomic groups. It was not possible to get completely accurate information concerning the length of time the ex-patient had been in the community or the number of times

hospitalized, so that important variable was not adequately controlled. Also the patients' statuses varied with some on convalescent leave and others discharged or in some cases without a clearly defined legal status. The sample did consist of an all-white population. Negroes were excluded from the survey because, at that time, Oklahoma Mental Institutions were racially segregated.

The final sample of former mental patients studied included twenty-eight males and twenty-two females. Twenty-nine (58 per cent) of the total sample were married which included seventeen males and twelve females. Twenty-one (42 per cent) of the total sample were single, five of these divorced or separated and one widowed (see Table III).

TABLE III

MARITAL STATUS OF RESPONDENTS
BY SEX DISTRIBUTION

Marital Status	Male	Female	Total
Married	17	12	29
Single	10	5	15
Divorced or Separated	1	4	5
Widowed	0	1	1
Total Number	28	22	50

Collection of Data

Research Procedures

Two weeks prior to the start of the survey, letters were mailed to each ex-patient or responsible relative at the address listed in hospital

records or in the files of the Tulsa Mental Health Association. These letters (Appendix A) explained the nature of the project and asked each patient or responsible relative to sign a permission slip giving approval for an interview by a representative of the Oklahoma Department of Mental Health. Respondents were then contacted either by phone or in person and arrangements made to pick up permission slips. At this time, the ex-patient and his family were given details about the study. This technique was effective in establishing contact and rapport with respondents and family members. This was evidenced by a low rate of refusals (considering that approval had to be given by both the ex-patient and family members) and friendly attitudes which were expressed by most respondents after the interview was completed. At the completion of each interview schedule, the interviewer rated each respondent in terms of certain characteristics surrounding the interview situation. These ratings are summarized in Table IV.[4]

Data in this table indicate that most of the interviews were conducted under relatively favorable conditions. There were few serious distractions during the interviews and a majority of the respondents were friendly or even solicitous. Those who were suspicious or guarded usually became friendly after they were assured that the interviewer did not represent a threat to them or their status.

The interview was conducted by the research director and the writer during the summer months of 1964.[5] The actual interview took about an hour and in most cases it was arranged that the interviewer be of the

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[4]Ibid., p. 10.

[5]Ibid., p. ii.

TABLE IV

CONDITIONS UNDER WHICH INTERVIEWS WERE CONDUCTED AND ATTITUDES OF RESPONDENTS TOWARD INTERVIEW

Distraction During Interview	Number	Percent
Much Distraction	7	14.3
Some or Occasional Distractions	11	22.4
No Distractions	31	63.3
Don't Know	--	--
Total	49	100.0

Attitudes of Respondents Toward Interview	Number	Percent
Hostile	2	4.1
Suspicious, Guarded	18	36.7
Friendly	23	46.9
Solicitous	6	12.2
Don't Know	--	--
Total	49	99.9

same sex as the respondent. While the ex-patient was being interviewed, a responsible relative (husband, wife or other) was interviewed in a separate room and asked to fill out a symptom or behavior rating sheet (Appendix B). In four cases, the responsible relative insisted on being present during the interview. These requests were honored. The ideal desired was to conduct the interview with the ex-patient alone in order to lessen the influence of the other family members on his answers. The interview was conducted in the homes of the ex-patients.

The Research Instrument

The primary source of data was the interview with the ex-patient. The instrument used was a type of open-ended interview schedule. The method chosen was to have each interview item focus attention upon a given experience and its meaning for the respondent, but the provisions were made in the schedule for probing in whatever direction seemed to be most rewarding in terms of the information needed. There was a manual developed which explained the purpose and objective of each item. The complete interview schedule (Appendix C) consisted of eighteen questions or items listed under four major headings. Each major heading represented general areas of concern in the survey: (1) employment and work roles (on job and/or at home), (2) family interaction, (3) use of time and other social ties and activities, and (4) use of community resources.[6]

In the original research design two instruments were to be used in order to obtain the data. One was the interview schedule, previously discussed, which was to be given in the ex-patient's home environment. Other data, primarily related to cultural and personality characteristics and diagnostic categories were to be obtained from the hospital records of the patients. These records were made available for study by the Department of Mental Health in conjunction with this overall research project. After examining a few of these records, however, it became apparent that there were so many serious limitations in the hospital records that they were not adequate for obtaining reliable data on the ex-patient. In relation to the diagnostic categories, for

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[6]Ibid., p. 7.

example, patients who had been in the hospital more than once would often have a different diagnosis every time; or, in some cases, there was no diagnosis at all. These findings support those of Pasamanick who has questioned the reliability of diagnostic categories in hospital records.[7]

Before proceeding to further discussion of the research design, there are several limitations of sample and of methodology which should be recognized. First, the size of the sample has been affected by the high mobility rate of this population. Many ex-patients had left the areas previously selected, or could not be located because of high mobility and lack of contact with existing social agencies. Second, the home environment creates certain problems with family members. If family members were present during the interview, then it was possible that the ex-patient's answers regarding the expectations of family members could have been biased. Third, the data-collection and interview techniques were limited by the fact that there was no presurvey nor any opportunity to adequately pretest the schedule. There was also a great deal of difficulty in standardizing and coding open-ended questions.

Definitions of Significant Concepts

In this study the concepts which are of upmost importance in understanding the problem of readjustment of the former mental patient include those of instrumental role performance (both occupational and social), structural characteristics of families, attitudinal characteristics of

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[7]Benjamin Pasamanick, Simon Dinitz and Mark Lefton, "Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital," American Journal of Psychiatry 116 (August, 1959), pp. 127-132.

significant others, including expectation levels and stigma.

Instrumental Role Performance

The behavior of individuals in occupational and social roles was chosen as an appropriate social situation in which to obtain some indication of the degree of readjustment. These factors, which will be referred to as instrumental performance, are similar to those reported by Freeman and Simmons who examined the former patients' work and social participation.[8] For purposes of this study, instrumental simply means that something is carried out or executed in action. This action is executed in terms of a role, defined as behavior oriented to patterned expectations of others. Role is a concept serving to connect culturally defined expectations with the patterned conduct and relationships which make up a social structure.[9] This involves requirements laid down by other members of society for behavior in a variety of situations. The behavior required of a person in a given position in society is considered to be his prescribed role, and the requirements themselves can be called role-prescriptions. Role-prescriptions are composed of statements about the behavior which one must display in the role. It follows that conformity and deviance, reckoned as they are in terms of the role-prescription, must refer to variations in behavior from these role-prescriptions.[10]

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[8]Freeman and Simmons, The Mental Patient Comes Home, pp. 48-61.

[9]Robert K. Merton, "The Role Set: Problems in Sociological Theory," British Journal of Sociology 8 (June, 1957), p. 110.

[10]Orville G. Brim, Jr., "Personality Development as Role-Learning," Personality Development in Children, eds. Ira Iscoe and Harold Stevenson (Austin, 1960), pp. 130-131.

In previous research, measures of adjustment have included the areas of occupation, social participation, and family life. The participation of former mental patients in these areas of life were considered as aspects of their readjustment and rehabilitation.[11] These variables have been used because the study of role behavior must include a selection of the descriptive dimensions to be used in comparing individual performances in various situations. Instrumental role-performance is overt, it is observable. Merton, for example, borrows the concept of observability from Simmel and means by it the extent to which social norms and role-performances can readily become known to others in the social system.[12]

In this study, instrumental role-performance is operationally defined in quantitative terms regarding work and social participation of the former mental patient. The following are the descriptive dimensions chosen in order to compare individual performances in these situations. The level of the ex-patient's participation in a work situation after his release from the hospital is indicated by the use of four categories. These categories range from low participation, when the ex-patient has not been gainfully employed in a job since his release or has worked less than half time, to high participation, when he has worked regularly or more than half time since his release. The following numbers are assigned to each category:

1. Not gainfully employed since release

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[11]Leta M. Adler, "Patients of a State Mental Hospital: The Outcome of Their Hospitalization," Mental Health and Mental Disorder, ed. Arnold Rose (New York, 1955), pp. 512-515.

[12]Merton, p. 114.

2. Worked less than half time since release

3. Worked more than half time since release

4. Worked regularly since hospitalization

Those unemployed in jobs outside the home may still have a work role to perform in the home. The work participation of the housewife and nonworker is also divided into four categories ranging from low participation to high participation. The following numbers are assigned to work performance levels in the home:

1. Does nothing; no responsibilities

2. Minor tasks...very few...dust or wash dishes, mow lawn or make beds

3. Major tasks...limited responsibility...care for children, handle money with other members of the family

4. Full time responsibilities of home and family

Social performance is also ranked in terms of four categories ranging from low participation to high participation, with the following numbers indicative of each level:

1. No participation in organizations; visited and was visited less than twice a month...

2. No participation in organizations; visited and was visited as often as two or three times a week...

3. Belongs to at least one organization and attends one to three meetings a month; visited and was visited once a week or less...

4. Belongs to at least one organization and attends four or more meetings a month; visited and was visited more than once a week...

In order to have a measure of the dependent variable, instrumental role performance, it was necessary to combine the indexes of social and

work participation into one category for performance and to assign levels to this category of performance. As previously indicated, each level of work performance was given a number, ranging from low to high participation (1-4). Each level of social performance was likewise given the same weight. In order to assign an overall level of instrumental performance, the two numbers, the one ranking work participation and the other ranking social participation, were added together. The lowest possible number obtained was two, the highest eight. For example, if an ex-patient had not been gainfully employed since release, or if unemployed, had no responsibilities at home, and did not participate in organizations and was visited less than twice a month, the social and work participation numbers were added and he would be given the rank number of 2 and placed in a LOW level of instrumental performance.

Structural Characteristics

Freeman and Simmons found an association between the level of instrumental performance of the patient after hospitalization and characteristics of his family setting. They identified those characteristics of patients and their families that were related to variations in the performance of the patient. These characteristics were variables correlated with the expectations of relatives.[13] The argument was that the differential demands and expectations of family members in different

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[13]Ozzie G. Simmons and Howard E. Freeman, "Familial Expectations and Post-Hospital Performance of Mental Patients," Human Relations 12 (August, 1959), p. 237.

family settings constitute key variables in the posthospital performance of patients.[14]

Since role-prescriptions vary with different social situations, it is important to know the kind of a family unit in which the patient is living in order to understand the different role performances. A patient's kin role, that of husband or son, for example, defines to a considerable extent what is right and proper behavior. Structural characteristics which are correlated with expectation levels embodied in the social system itself include: (a) the kin relationship of the former patient, whether a spouse, child or other; (b) the setting of the family whether in a conjugal relationship, parental relationship or living alone; and (c) the number of other workers in the family to fill the role that otherwise would be expected of the ex-patient. Therefore, to operationally define structural characteristics of the social system called the family, three indexes were developed which included:

1. Marital status: married, single or other
2. Family setting: conjugal, parental or other
3. Number of full-time workers in the household other than the ex-patient: None, one or more

Attitudinal Characteristics

Attitudes are defined as enduring systems of positive or negative evaluation, emotional feelings, and pro or con action tendencies with respect to social objects.[15] Attitudinal characteristics which were

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[14]Freeman and Simmons, The Mental Patient Comes Home, p. 101.

[15]David Krech, Richard S. Crutchfield and Egerton L. Ballachey. Individual in Society (New York, 1962), p. 139.

tested with respect to the ex-patients' performance levels include expectations of family members and feelings of rejection and stigma. The individual holding a given position has role-prescriptions concerning an understanding of what the others expect of him.[16] Expect is a strong word implying some ground or reason in the mind for considering the event as likely to happen. Freeman and Simmons found an association between level of performance and the expectations of family members with regard to the patient's behavior. In fact, high performance levels were found most likely to occur in settings in which relatives not only held expectations of high performance but claimed that they would insist upon them.[17] In research reported by Freeman and Simmons, however, the family members were interviewed concerning <u>their</u> expectations for the former patient. There is a possible limitation in this method because the expectations of family members are relevant only <u>in terms of the patients' perception of them.</u>[18] In this connection, it is possible that the patient has not accurately perceived expectations or that expectations of others are not always adequately communicated. In fact, family members may express expectations (overtly or covertly) that they themselves are not aware of or sensitive to. Therefore, in this research, expectations and insistence on performance were measured in terms of the former patients' perception of expectations. It was felt that the patients' perceived expectations would be more significantly related to their instrumental role performance. Levels of

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[16]Brim, p. 130.

[17]Freeman and Simmons, <u>The Mental Patient Comes Home</u>, p. 142.

[18]Ibid., pp. 139-152.

expectancy and insistence on adequate performance for the former mental patient were measured in terms of five performance areas: visiting relatives, visiting friends, helping entertain at home, go to parties and other social events with the family, and work full time either at a job or in the home.

What members of the community do with and for the patient contribute to his image of himself as fitting into or being apart from his community and influences the roles he can play. Thus, the community's attitudes and actions toward the patient can constitute a negative block or a positive asset in helping him gradually resume full participation with others. Stigma refers to the sensitivity of relatives or the patient himself to the reactions of family, friends, and work associates regarding hospitalization for mental illness. "The current attitudes toward mental illness that are held by community members, and their resulting detrimental affects on patients and their families, are often regarded as a major barrier to the reintegration of formerly hospitalized persons into the community"[19]

There are two connotations to stigma. One is that the person is set apart in the minds of others, i.e., different from the so-called normal person. It also implies that he is set apart by a mark which is felt to be disgraceful and by which he is judged to be inferior. These

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[19]Howard E. Freeman and Ozzie G. Simmons, "Feelings of Stigma Among Relatives of Former Mental Patients," Social Problems 8 (Spring, 1961), p. 313.

attitudes stigmatize the patient, and thereby interfere with his rehabilitation.[20] Freeman and Simmons found a significant correlation between performance levels and relatives' feelings of stigma.[21] The writer is not aware of any research which attempts to measure the former mental patient's own feelings of stigma and rejection by others. It would appear to be much more significant for the ex-patient's performance level to know how he perceives stigma. Therefore, three categories were developed in order to measure feelings of stigma which were based on the ex-patient's response. These quantitative levels were the following: none, moderate, and strong. None referred to those patients who had had no perception or awareness of negative feelings stemming from others, nor feelings of being defined differently by other people because of the status of mental patient. Moderate feelings of stigma were defined as the recognition of negative definitions of the status of "mental patient," awareness of rejection by employers because of the status, but no feelings of personal rejection and no desire to conceal the facts about oneself. Strong feelings of stigma included all the feelings in the moderate category plus strong feelings of personal rejection by using such phrases as: "People shun me," "Off the beam," "Think you're crazy," "Avoid you," "Think you're nutty." Strong feelings of stigma are accompanied by a desire to withdraw and conceal the facts about oneself.

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[20]Charlotte Green Schwartz, "The Stigma of Mental Illness," Journal of Rehabilitation 22 (July-August, 1956), p. 7.

[21]Freeman and Simmons, The Mental Patient Comes Home, p. 162.

Hypotheses

The hypotheses in null form state the relationships between the former mental patient's instrumental role performance level and certain possible significant independent variables which are all related to role expectations.

HO_1 There is no relationship between the former mental patient's instrumental performance level and the structural characteristics of his family.

Corollary 1: There is no relationship between the former mental patient's instrumental performance level and the number of full-time workers in the household other than himself.

Corollary 2: There is no relationship between the former mental patient's instrumental performance level and the type of family setting (parental, conjugal or other).

Corollary 3: There is no relationship between the former mental patient's instrumental performance level and his marital status (married, single or other).

HO_2 There is no relationship between the former mental patient's instrumental performance level and the attitudinal characteristics of family members, employers and other community members.

Corollary 1: There is no relationship between the former mental patient's instrumental performance level and his perception of the level of family expectations and insistence on adequate performance.

Corollary 2: There is no relationship between the former mental patient's instrumental performance level and his perceived feelings of rejection and stigma.

CHAPTER III

DATA ANALYSIS

The dependent variable throughout the study is the former mental patient's instrumental performance level, both social and occupational as defined operationally in the previous chapter. Table V reveals the level of instrumental performance in the work role. This table combines the categories of those employed in jobs and those working at home, recognizing the different social situations, but treating them as equal measures of work role performance. Table VI reveals the level of instrumental performance in the social role. Table VII reveals the number of former mental patients in each instrumental performance category using three levels. The data are further simplified in Table VIII by combining the categories into two levels of participation: low and high. The scores used to designate different performance levels are also summarized in Table VII and Table VIII.

This dependent variable (instrumental performance level) is correlated with several independent variables indicative of role expectations for the former mental patient. The first set of variables are the structural characteristics of the family as embodying role expectations, and are stated in terms of the following hypothesis and corollaries:

HO_1 There is no relationship between the former mental patient's instrumental performance level and the structural characteristics of his family.

Corollary 1: There is no relationship between the former mental patient's instrumental performance level and the number of full-time workers in the household other than himself.

TABLE V

LEVEL OF INSTRUMENTAL PERFORMANCE: WORK ROLE

Level of Work Performance	Male	Female	Total
Does nothing. (1)	14	4	18
Has worked less than half time; or minor tasks in the home. (2)	7	8	15
Has worked more than half time; or major tasks in the home. (3)	1	7	8
Regular work; or full-time responsibilities in the home. (4)	6	3	9
Total Number	28	22	50

TABLE VI

LEVEL OF INSTRUMENTAL PERFORMANCE: SOCIAL ROLE

Level of Social Performance	Male	Female	Total
No participation; visit less than twice a month. (1)	10	5	15
No participation; visit two or three times a week. (2)	9	5	14
Participates in one organization 1 to 3 times a month; visits once a week or less. (3)	7	5	12
Participates in one organization 4 or more times a month; visits more than once a week. (4)	2	7	9
Total Number	28	22	50

TABLE VII

THREE LEVELS OF INSTRUMENTAL PERFORMANCE:
WORK ROLE + SOCIAL ROLE

Level of Performance	Male	Female	Total
Low (2-3)	12	5	17
Moderate (4-6)	12	12	24
High (7-8)	4	5	9
Total Number	28	22	50

TABLE VIII

TWO LEVELS OF INSTRUMENTAL PERFORMANCE:
WORK ROLE + SOCIAL ROLE

Level of Performance	Male	Female	Total
Low (2-4)	20	8	28
High (5-8)	8	14	22
Total Number	28	22	50

Table IX reveals the number of former mental patients with no other full-time workers in the household or one or more other full-time workers.

TABLE IX

NUMBER OF FULL-TIME WORKERS IN HOUSEHOLD OTHER THAN EX-PATIENT

Number of Workers	Male	Female	Total
None	13	6	19
One or more	15	16	31
Total Number	28	22	50

It has been assumed that if there are no other full-time workers in the family, the ex-patient's role expectations will be greater than if there was someone else to fill the role. Two categories were assigned to this variable; either there were no other full-time workers, or there were one or more. Twenty per cent of the former mental patients with no other full-time workers in the family had a low performance level while eighteen per cent had a high performance level (see Table X). Thirty-six per cent of the former mental patients who had one or more full-time workers in the family had a low performance level while twenty-six per cent had a high performance level. To test this corollary the chi-square test of independence was applied to the data. The value of chi-square is .1411 which is not significant at the .05 level of confidence; therefore, the null hypothesis cannot be rejected.

TABLE X

NUMBER OF FULL-TIME WORKERS IN THE FAMILY
AS RELATED TO PERFORMANCE LEVEL

	Number of Workers Other Than the Patient		
Performance Level	None	One or More	Total
Low	10	18	28
High	9	13	22
Total Number	19	31	50

$X^2 = .1411$, $p > .05$

Corollary 2: There is no relationship between the former mental patient's instrumental performance level and the type of family setting (conjugal, parental or other).

Corollary 3: There is no relationship between the former mental patient's instrumental performance level and his marital status (married, single or other).

The number of former mental patients married and single has already been shown (see Table III). Table XI reveals the number living in a conjugal or parental and other family setting.

TABLE XI

FAMILY SETTING OF EX-PATIENTS ACCORDING TO LIVING ARRANGEMENTS

Family Setting	Male	Female	Total
Conjugal	17	12	29
Parental or other	11	10	21
Total Number	28	22	50

The second and third corollaries are concerned with the significance of marital status and living arrangements in relation to performance levels. Other research has supported the view that marital status and living arrangements are highly related to posthospital functioning. Freeman and Simmons, for example, found a high correlation between marital status and conjugal family units and high performance levels.[1] In research reported by Dinitz it was found that those patients who were married and returned to a conjugal setting were over-represented among the high performers.[2] It is argued that more will be expected of a

[1]Howard E. Freeman and Ozzie G. Simmons, The Mental Patient Comes Home (New York and London, 1963), pp. 92-93.

[2]Simon Dinitz, Mark Lefton, Shirley Angrist, and Benjamin Pasamanick, "Psychiatric and Social Attributes as Predictors of Case Outcome in Mental Hospitalization," Social Problems 8(Spring, 1961), pp. 327-328.

patient in a married status living in a conjugal family unit and that his performance will match these expectations. All those patients who were married were also living in the conjugal family unit, and the single, divorced, and widowed patients were living in a family setting with parents, siblings or by themselves (see Tables III and XI). Therefore since the structural characteristics of marital status and family settings were the same, the categories were combined and Corollaries 2 and 3 were examined together. Twenty-eight per cent of the low performers were married and living in a conjugal family unit and twenty-eight per cent were single living with either parents, siblings, or alone. However, thirty per cent of the high performers were married and only fourteen per cent were single which suggests a definite trend toward higher performance for the married former patients. The chi-square value in this case is 1.673 which is not significant at the .05 level of confidence; and the null hypothesis cannot be rejected.

TABLE XII

MARITAL STATUS AND FAMILY TYPE AS RELATED TO PERFORMANCE LEVEL

Performance Level	Married and Living in a Conjugal Setting	Single, Divorced or Widowed and Living with parents, siblings, or alone	Total
Low	14	14	28
High	15	7	22
Total Number	29	21	50

$X^2 = 1.673, \; p > .05$

A careful look at data not included in Table XII suggests the factor of age might be an intervening variable which is more significant among the low performers than the high performers. There is a higher percentage of married represented among the low performers than would be expected in terms of the trend for the married among the high performers. The older married people may have been rated as low performers because they were past the age of working or because they were physically unable to assume heavy responsibilities around the house.

HO_2 There is no relationship between the former mental patient's instrumental performance level and the attitudinal characteristics of family members, employers and other community members.

Corollary 1: There is no relationship between the former mental patient's instrumental performance level and his perception of the level of family expectations and insistence on adequate performance.

Table XIII reveals the levels of expectancy and insistence in relation to each performance area which was questioned.

TABLE XIII

PERCEIVED EXPECTATIONS AND INSISTENCE OF FAMILY MEMBERS IN FIVE PERFORMANCE AREAS

Performance Area	Neither expect or insist	Expect but not insist	Both expect and insist
Visit relatives	11	23	16
Visit friends	16	18	16
Help entertain	14	19	17
Go to parties, social events	24	14	12
Work full time	26	14	10

The second set of variables indicative of role expectations for the former mental patient are attitudinal characteristics measured in terms of these perceived expectations of family members and perceived stigma and rejection by others. As indicated in Chapter II, perceived expectations of family members were measured by these five behavior areas (see Table XIII). To test this corollary, the chi-square test of independence was applied to each behavior area related to performance level (Table XIV).

The first three behavior items listed are not significant at the .05 level of confidence. There is, however, a definite direction evident in the item of visiting friends. Of the sixteen ex-patients who perceived neither expectations nor insistence on visiting friends, twelve (seventy-five per cent) were low performers. Concerning the item, helping entertain at home, of the fourteen who perceived neither expectations nor insistence, seventy-one per cent were low performers. The last two behavior items were significant at the .05 level of confidence, and therefore the null hypotheses could be rejected. In relation to the behavior item of going to parties and other social events, of the twenty-eight low performers, eighteen (sixty-four per cent) perceived neither expectations nor insistence on going out to parties, and four (fourteen per cent) perceived expectations and insistence on such performance. The high performers revealed only a slight trend toward higher expectations. Concerning the item of working full time there was a significant relationship between low performance and lack of perceived expectations and insistence. The item included working full time either at a job or in the home. Forty per cent of the total ex-patient population who perceived neither expectations nor insistence on

TABLE XIV

EXPECTATION-INSIST SCALES IN FIVE PERFORMANCE AREAS

AS RELATED TO PERFORMANCE LEVEL

Performance Area	Performance Level	Not Expect or Insist	Expect Not Insist	Expect and Insist	Chi-Square Value	Level of Significance
Visit Relatives	Low	8	11	9	1.8703	$p > .05$
	High	3	12	7		
Visit Friends	Low	12	8	8	3.553	$p > .05$
	High	4	10	8		
Help Entertain	Low	10	9	9	1.989	$p > .05$
	High	4	10	8		
Go to Parties and Other Social Events	Low	18	6	4	6.999	$p < .05$
	High	6	8	8		
Work Full Time	Low	20	4	4	9.93	$p < .01$
	High	6	10	6		

working full time were low performers. This compares with eight per cent who were low performers and perceived both expectations and insistence on working full time. Twenty per cent of the patients were high performers who perceived expectations but not insistence on adequate performance although there is no significant trend within the high-performing population.

TABLE XV

A SUMMARY OF CHI-SQUARE VALUES AND LEVELS OF SIGNIFICANCE IN FIVE PERFORMANCE AREAS

Performance Area	Chi-Square Value	Degrees of Freedom	Level of Significance
Visit relatives	1.8703	2	$p > .05$
Visit friends	3.553	2	$p > .05$
Help entertain	1.989	2	$p > .05$
Go to parties and other social events	6.999	2	$p < .05$
Work full time	9.93	2	$p < .01$

The final independent variable to be considered under the second hypothesis is the stigma and rejection item as perceived by the former mental patient.

Corollary 2: There is no relationship between the former mental patient's instrumental performance level and his perceived feelings of rejection and stigma.

Table XVI reveals the number of former patients who were in each category of perceived strength of stigma and rejection by employers and the community. The feelings of stigma were divided into three quantitative categories which are explained in Chapter II. There are those

TABLE XVI

PERCEPTION OF STIGMA BY THE EX-PATIENT

Amount of Stigma Perceived	Male	Female	Total
None	3	10	13
Moderate	11	9	20
Strong	13	3	16
Total Number	27	22	49

who perceived no stigma, moderate stigma, and strong stigma. Among the sixteen former mental patients who perceived strong stigma, seventy-five per cent are low performers and twenty-five per cent high performers. Among those who perceived moderate stigma, thirty-five per cent are low performers and sixty-five per cent are high performers (see Table XVII). The same consistency does not hold for those perceiving no stigma at all for sixty-nine per cent are low performers and thirty-one per cent are high performers. The results of the moderate and strong categories indicate that those who perceived stigma and rejection personally are most seriously affected in their social and occupational participation. The greater number of low performers in the strong category (twenty-four per cent of the total sample) might indicate a relationship between perception of stigma personally and withdrawal from the social and occupational scene, thus emphasizing the threat that stigma presents to the former mental patient. The fact that a large number of high performers are in the moderate category suggests that an awareness of stigma may occur because of high participation in the community but apparently as long as it is not perceived personally it does not

constitute a threat to the ex-patient. The chi-square value is 6.865 which is significant at the .05 level of confidence and the null hypothesis can be rejected.

TABLE XVII

PERCEPTION OF STIGMA AS RELATED TO PERFORMANCE LEVEL

	Amount of Stigma Perceived			
Performance Level	None	Moderate	Strong	Total
Low	9	7	12	28
High	4	13	4	21
Total Number	13	20	16	49

$X^2 = 6.865$, $p < .05$

Summary of Results

In the course of this investigation, statistical tests were made for four hypotheses including one (Hypothesis III) in which five separate statistical tests were used. The data upon which statistical tests were made were from a total of fifty former mental patients interviewed in the Tulsa Metropolitan Area during the summer months of 1964. This section includes a summary of the hypotheses that were tested and their dispositions. Also given is the type of statistical test utilized in testing each hypothesis. Conclusions and recommendations based on these findings are presented in the final chapter.

I. Hypothesis

There is no relationship between the former mental patient's instrumental performance level and the number of full-time workers in the household other than himself.

Statistical Test

Chi-square = .1411, 1 d.f.

Level of Significance

$p > .05$

Disposition of Hypothesis

Null: Confirmed

II. Hypothesis

There is no relationship between the former mental patient's instrumental performance level and his marital status and type of family setting.

Statistical Test

Chi-square = 1.673, 1 d.f.

Level of Significance

$p > .05$

Disposition of Hypothesis

Null: Confirmed

III. Hypothesis

There is no relationship between the former mental patient's instrumental performance level and his perception of the level of family expectations and insistence on adequate performance. The perceived expectations are measured in terms of social behavior in five areas.

(a) Visiting Relatives

Statistical Test

Chi-square = 1.8703, 2 d.f.

Level of Significance

$p > .05$

Disposition of Behavior Area

Null: Confirmed

(b) Visiting Friends

Statistical Test

Chi-square = 3.553, 2 d.f.

Level of Significance

$p > .05$

Disposition of Behavior Area

Null: Confirmed

(c) Helping Entertain at Home

Statistical Test

Chi-square = 1.989, 2 d.f.

Level of Significance

$p > .05$

Disposition of Behavior Area

Null: Confirmed

(d) Go to Parties and Other Social Events

Statistical Test

Chi-square = 6.999, 2 d.f.

Level of Significance

$p < .05$

Disposition of Behavior Area

Null: Rejected

(e) Be Working Full Time

Statistical Test

Chi-square = 9.93, 2 d.f.

Level of Significance

$p < .01$

Disposition of Behavior Area

Null: Rejected

IV. Hypothesis

There is no relationship between the former mental patient's instrumental performance level and his perceived feelings of rejection and stigma.

Statistical Test

Chi-square = 6.865, 2 d.f.

Level of Significance

$p < .05$

Disposition of Hypothesis

Null: Rejected

CHAPTER IV

SUMMARY AND CONCLUSIONS

Summary of Findings

The principal objective of this study was to determine whether there was a relationship between the attitudinal components and expectations of significant others of former mental patients and the performance level of the patients. The subjects utilized in the study were fifty former mental patients, released from Eastern State Hospital during the period of February, 1961, through June, 1964.

The structural characteristics of the ex-patients' families in terms of marital status of the patient, living arrangement, and the number of full-time workers in the family were correlated with instrumental performance level and were not found to bear any significant relationship by the use of the chi-square test of significance. The null hypothesis, therefore, relating structural characteristics to performance levels of the ex-patient, could not be rejected. No significant relationship was found between the structural characteristics of families and the instrumental performance level of former mental patients. The lack of significant findings concerning this null hypothesis could possibly be attributed to several factors. The first and most obvious one is that there may actually be no relationship between the structural characteristics of a former mental patient's family and his instrumental

performance level. But other conclusions seem more plausible when breaking the hypothesis down into its corollaries and studying each one separately. The writer postulates, for example, that the number of full-time workers in the family may not be significantly related to the performance level of the ex-patient because of the intervening variable of sex. Females are more likely to have another full-time worker in the family whereas the male is expected to be the primary worker. This was illustrated by the fact that of the twenty-two ex-patients classified in the high-performing category fourteen were female and eight male. Of the nineteen ex-patients who say there were no other full-time workers in the family thirteen were male and six female. These two factors might be interacting in such a way that they cancel out each other.

A third possibility is that the absence of significant relationships between marital status or living arrangements and the instrumental performance level could be attributed to the intervening variable of age. The large number of married found among the low performers may be the result of the fact that a large number of the patients were older and past the age of working. Thus, there was insufficient control of age and sex factors as these might alter relationships between structural characteristics and role expectations.

The perceived expectations and insistence of family members on performance in five situations involving interaction with others was found to be significantly related to the performance levels of the patients in two of the five areas. The behavior situations dealing with visiting relatives, friends or helping entertain at home were not found to be significantly related to the instrumental performance level of the ex-patient. There was a significant relationship found between

perceived expectations and insistence on going to parties, other social events and working full time and that of instrumental performance level. The writer postulates that this significance is due to the environmental nature of these two performance areas. In the two significant behavior areas the former mental patient is brought into contact with the community at large. Because of this fact, it is also expected that there would be a positive relationship between these two behavior areas (expectations of going to parties, other social events and working full time), and the independent variable of feelings of rejection and stigma which is discussed in the next paragraph.

The final null hypothesis relating instrumental performance levels and the ex-patient's perceived feelings of rejection and stigma was rejected. There was a particularly significant relationship between low performance and strong personal perception of rejection and stigma. The high performers are found to be clustered in the moderate category of perception of stigma. An awareness of the attitudinal component of stigma attached to the status of mental patient apparently does not significantly hamper social and occupational performance. But when stigma is perceived as a personal rejection it may present a threat to the ex-patient which could result in his withdrawal from the social and occupational scene.

Theoretical Implications

The interpretations of the findings of this study have implications for the theoretical positions of other researchers. In studying the role performance of former mental patients there have been some who feel that a maximum tolerance of deviant behavior provides a better

environmental situation for the returning mental patient.[1] The prevalent view in mental health has been that there should be a continued acceptance of the ex-patient even when he is not performing adequately in instrumental roles. The opposite view has been expressed by Freeman and Simmons[2] who conclude that high performance is produced by a minimum tolerance of deviance combined with high expectations for the ex-patient. They postulate that family structure is related to differing expectation levels and that a family characterized by high expectations is more likely to encourage movement toward high performance. Dinitz, et. al.,[3] also found that family structure, i.e., marital status and living arrangements, is highly related to functioning. For example, a patient returning to a conjugal family setting would perform better than one returning to a parental family. It has been assumed that greater pressure for success would more likely be translated into better performance. The dynamics underlying this assumption are attitudinal in nature. Adler[4] has also postulated that family structure is

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[1]See A. Green, "The Middle-Class Male Child and Neurosis," American Sociological Review 51 (February, 1946), pp. 31-41; Edwin Lemert, Social Pathology, (New York, 1951); and Richard T. LaPiere, A Theory of Social Control (New York, 1954).

[2]Ozzie G. Simmons and Howard E. Freeman, "Familial Expectations and Post-Hospital Performance of Mental Patients," Human Relations 12 (August, 1959), pp. 233-242.

[3]Simon Dinitz, Mark Lefton, Shirley Angrist and Benjamin Pasamanick, "Psychiatric and Social Attributes as Predictors of Case Outcome in Mental Hospitalization," Social Problems 8 (Spring, 1961), pp. 322-328.

[4]Leta M. Adler, "The Relationship of Marital Status to Incidence of and Recovery from Mental Illness," Social Forces 32 (December, 1953), p. 194.

related to functioning. It was found that married life makes for high probability of recovery. The variables investigated in married life, however, differed from those of the other researchers. Adler postulated that the emotional security and social stability afforded by married life are conducive to better recovery. In summarizing previous research, the type of living arrangement to which a patient returns has been regarded as of upmost importance in its influence on his adjustment. Measuring adjustment by instrumental performance level, this study does not support the theoretical position of Freeman and Simmons, Dinitz and Adler. Family structure, defined in terms of marital status of the patient, living arrangement, and the number of full-time workers in the family, when correlated with instrumental performance level, was not found to bear any significant relationship. It was hypothesized, however, that these results could have been attributed to the intervening variables of sex and age which were not adequately controlled in this study. Given control of these variables, it may be that role-expectations are embodied in family structure and are related to the performance level of the ex-patient. Further research is needed in this area.

The more general view supported by Freeman and Simmons that the role expectations and attitudinal factors of significant others are related to the performance level of the former mental patient is supported in part by this study. There was a significant relationship found between perceived expectations and insistence on going to parties, other social events, and working full time and that of instrumental performance level. But the behavior situations dealing with visiting relatives, friends, or helping entertain at home were not found to be

significantly related to the instrumental performance level of the ex-patient. The data from this study imply that those role expectations and attitudinal factors which are significantly related to performance level are those which involve behavior expectations outside the family. A particularly significant relationship was found between low performance and strong personal perception of rejection and stigma by others in the community. It would seem that when the former patient perceives a strong personal rejection outside the family because of his status as a former mental patient it is related to a lower performance level. The higher the expectations, including those that are perceived from others outside the family, the higher will be the performance level.

The development of the theoretical implications of this study lead us to consider areas that require additional research. There needs to be further research in what kinds of expectations in the family and outside the family are significant in their relation to instrumental performance level. In this area, research techniques need to be developed which could simultaneously look at both expectations in the family and those outside the family. Also, further study is needed in order to determine whether or not there is a significant factor which may prove to be so important that it prevails over general role expectations. For example, some of the evidence which has been presented suggests that personal rejection is the significant factor affecting personal performance on the part of the respondents in this study.

Limitations

In interpreting the findings of this investigation, the reader should be aware of certain methodological limitations. A brief discus-

sion will be presented here of factors which may have substantially influenced the results of the study.

One limitation in this investigation is the size of the sample. There was a great deal of difficulty in locating respondents and the sample had to be limited. As a result, two very basic and important variables were not controlled. These variables, age and sex, are particularly important in terms of role expectations and performance levels. The sample is also biased toward the lower socioeconomic levels, the lower educational levels, and the more stable residentially of the patient population.

A second limitation, also related to the first, is a lack of control over the variables of kind and degree of mental illness. This could be an important intervening variable affecting differing performance levels. Another uncontrolled variable is the ex-patient's perception as to whether or not certain expectations are legitimate. His attitudes toward the perceived expectations could be related to his motivation to meet the expectations of significant others. These motivation variables were not adequately controlled in this study. These could be important intervening variables affecting differing performance levels.

Conclusions

In view of the limitations discussed in the preceding section, a conservative interpretation would appear to be in order for the findings of this study.

The writer concludes that the former mental patient's perception of certain attitudinal components of significant others influences his

social and occupational performance. Should he perceive low expectations from family members in behavior areas outside the home and strong personal rejection and stigma from community members, he is more likely to have a low level of performance.

A suggestion for further research would be to investigate a general level of expectations which are relevant only in the internal system of the family and not influenced by perceived feelings of rejection by those outside the home. It would also be a contribution to the study of rehabilitation to investigate the influence of expectation levels of family members that uses health variables instead of performance as indicators of posthospital adjustment. The variable, performance level, is not necessarily indicative of the state of mental health of the ex-patient. For example, a hyper-active person may have a high performance level and still be seriously ill, and an ex-patient who has always personally perferred a more isolated life may be quite healthy. Therefore, the study of <u>mental health</u> as the significant dependent variable, rather than performance level, might prove to be a more significant indicator of posthospital adjustment.

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APPENDIX A

TULSA BRANCH
TULSA PSYCHIATRIC CLINIC FOUNDATION
1620 E. 12TH
TULSA, OKLAHOMA
LU 7-4326

McALESTER BRANCH
506 SOUTH 3RD
P.O. BOX 303
McALESTER, OKLAHOMA
GA 3-7477

STATE OF OKLAHOMA
COMMUNITY SERVICE PROJECT
DEPARTMENT OF MENTAL HEALTH
320 STATE CAPITOL
OKLAHOMA CITY, OKLAHOMA 73105
JACKSON 8-1044

Dear

During the summer months, the State Department of Mental Health is going to conduct a survey of former patients from Eastern State Hospital. We hope that you will be willing to be interviewed as part of this study.

We are attempting to gain enough information about the general problems that one faces in the local community so that we can be more helpful to people returning to their home communities from all of our state hospitals. We will be interested in such things as problems of finding a job, contacting old friends, making new ones, acceptance in the community, etc.. We will also be interested in how individuals have solved some of these problems.

I want to assure you that this will be a confidential interview and that no names will ever be in anyway connected with the material. We are interested in information only, and will not keep any record of names of individuals.

We realize that some of you may still have some questions about this study and might prefer not to be interviewed. If so, please feel free to discuss this with the representative from the Department of Mental Health who will contact you and make arrangements to pick up the permission slip at the bottom of the page. This representative will be happy to explain the study to you and answer any questions that you might have.

Thank you,

John H. Holt, ACSW
Consultant, Social Services
State Department of Mental Health

(Tear off here)

I give permission for a representative of the State Department of Mental Health to interview me or members of my family (if the family member desires) in connection with a study being conducted in the Tulsa area.

I understand that this is a confidential interview and that no names will ever be used in connection with information received.

SIGNED: _____
(Patient or Responsible Relative)

APPENDIX B

Here is a list of statements which family members have made regarding the behavior of former patients. Please check the behavior items appropriate in terms of frequently, occasionally, or never acting this way before hospitalization and since returning home.

BEFORE HOSPITALIZATION				AFTER HOSPITALIZATION			
Behavior	Freq.	Occ.	Never	Behavior	Freq.	Occ.	Never
Appears nervous				Appears nervous			
Worries or complains about his problem				Worries or complains about his problem			
Stays by himself				Stays by himself			
Thinks things look hopeless and feels unhappy				Thinks things look hopeless and feels unhappy			
Fails to keep to a time schedule				Fails to keep to a time schedule			
Appears in a daze				Appears in a daze			
Argues with family members				Argues with family members			
Thinks people talk about him				Thinks people talk about him			
Talks to himself				Talks to himself			
Forgets to do important things				Forgets to do important things			
Talks without making sense				Talks without making sense			
Drinks too much				Drinks too much			
Gets in debt by foolish buying				Gets in debt by foolish buying			
Hears voices				Hears voices			
Curses when strangers are around				Curses when strangers are around			
Damages, wrecks things				Damages, wrecks things			
Tries to hit/hurt someone				Tries to hit/hurt someone			
Argues with neighbors				Argues with neighbors			
Tries to commit suicide				Tries to commit suicide			
Cannot dress or take care of himself				Cannot dress or take care of himself			
Exposes himself indecently				Exposes himself indecently			

APPENDIX C

INTERVIEW SCHEDULE

The purpose of this interview is to try to understand some of the problems faced by people who have been in a state hospital. If we can understand these problems better, we can help people and make it easier for them to get along without going back to the hospital.

First, we would like to know something about your work and how this has been affected by your experiences in the hospital. For example, have you ever worked outside the home? (If yes, go to A.) (If no, go to questions for housewives or non-workers.)

I. Employment and Work Roles:

(1) A. We know that some people have trouble holding a job, especially before hospitalization. Were you working at that time?
If Yes: What was your job?

If No: How long had it been since you worked?

B. Have you ever looked for a job when you couldn't find one?
If Yes: Were you able to get help from anyone?

How did you feel about not having a job?

C. Some patients report that they have difficulty getting a job after being in the hospital. Have you run into problems getting a job? (Find out if presently employed, how often worked since release--more than half time or less?)

Do you feel that some employers are afraid to hire people who have been in the hospital?

(2) Series for Housewives and Non-workers:

A. What would you consider to be your most important job in the family? What do you do? (Probe for responsibility for household chores: dress & bathe children, dust, sweep, do usual cleaning, take care of laundry, prepare meals, handle money, etc

How has this changed since you have been in the hospital?

B. Some women (or men) report that they have difficulty readjusting to their jobs in the home. Have you found any difficulties along this line?

(3) Questions for both employed, Housewives, and Non-workers:

A. In your last job (or present job if working or a housewife or a non-worker) what are the things you like about the job best?

What are the things you like the least?

II. Now, we would like to ask a few questions about your family and how things have been since you returned from the hospital.

A. Are you married, divorced, single, widowed?

(If not married, or living with relatives, determine extent of family contacts.)

(How many are in the family and how many workers are there in the household?)

B. Every family has its good points and its bad points. What are some of the things about your family which you are not too happy about?

How did this change when you returned from the hospital?

C. Have you tried to do anything about the things you are not too happy about?

What did you do? (Determine if any social agencies were utilized.)

D. Some patients report that they have trouble "fitting in" when they return from the hospital. Have you ever felt this way?

If Yes: 1) What kind of things made you feel this way?

2) Have you discussed this with anyone?

If Yes or No: 3) In what ways has the family helped since you returned from the hospital?

E. We know that families vary a lot in the things that they do, such as visiting, etc. Would your family expect you to:
1. go along when they visit with relatives?
2. visit friends?
3. help at home when friends or relatives are expected?
4. go along with them to parties or dances or other social events?
5. work full time either at a job or in the house?

Would they insist that you: (repeat items)
1.
2.
3.
4.
5.

III. Some people have remarked that friends act diferently after a person has been hospitalized. We would like to discuss this problem now and get a little information about your friends and how you spend your time.

A. For instance, how do you usually spend your time when work is done?

What kinds of things do you do, both at home and away from home?

B. What are some things you would like to do?

C. Are you a member of any club or organization?
If Yes: How often do you attend?

D. How often do you get together with friends or relatives?...I mean things like going out together or visiting in each other's homes, etc.

IV. Now that we have discussed some of your activities and problems, we would like to get some idea about how people handle problems that come up in every day life.

A. For instance, everyone has problems which make them unhappy or nervous, (whether they are in the hospital or not). What kinds of things do you worry about most?

B. Suppose you were having a lot of problems and were not too happy most of the time. Where would you go to get help?

1) Is there some person you could call on?

2) Suppose your problems didn't get any better, and you felt that you had to have outside help; where could you go?

3) Have you ever gone any place for help since you returned from the hospital, such as say to a doctor, minister, or the like?

4) Do you know of any agencies or clinics where people can get help for problems which come up?
If Yes: How would you feel about going to these places?

C. One of the problems that patients face when they return from the hospital is the way other people act toward them. How have people's feelings about you changed since you were in the hospital?

1) How do people feel about individuals who have been in a state hospital?

2) Would you like it better if people did not know that you were in a state hospital?

V. This is about all the questions that we have to ask.
We would like to know when you were first hospitalized.
A. Date (approx.)_____P_____
B. How long did you stay?_____
C. When were you released?_____

Have you been to the hospital a second time?
A. Date (approx.)_____
B. How long did you stay?_____
C. When were you released?_____
(Repeat for each hospitalization)

INTERVIEWER RATINGS

1) House Type (Check One):

____ 1. Excellent houses.
____ 2. Very good houses.
____ 3. Good houses.
____ 4. Average houses.
____ 5. Fair houses.
____ 6. Poor houses.
____ 7. Very poor houses.
____ x. Did not see house.

2) Dwelling area (Check one):

____ 1. Very high.
____ 2. High.
____ 3. Above average.
____ 4. Average.
____ 5. Below average.
____ 6. Low.
____ 7. Very low.
____ x. Did not see dwelling area.

3) Rate the informant on each characteristic, even though you don't know him well. Ratings of 4 or 5 are almost neutral.

	Definitely Does Not Describe Subject								Definitely Describes Subject Well	
1. Is very active	0	1	2	3	4	5	6	7	8	9
2. Show solidarity & friendliness	0	1	2	3	4	5	6	7	8	9
3. Intelligence	0	1	2	3	4	5	6	7	8	9
4. Is very tense	0	1	2	3	4	5	6	7	8	9
5. Initiative	0	1	2	3	4	5	6	7	8	9
6. Makes other feel he understands them	0	1	2	3	4	5	6	7	8	9
7. Rationality and logic	0	1	2	3	4	5	6	7	8	9
8. Gets upset easily	0	1	2	3	4	5	6	7	8	9
9. Makes many suggestions	0	1	2	3	4	5	6	7	8	9
10. Likability	0	1	2	3	4	5	6	7	8	9
11. Clearmindedness	0	1	2	3	4	5	6	7	8	9
12. Tends to be nervous	0	1	2	3	4	5	6	7	8	9
13. Assertiveness	0	1	2	3	4	5	6	7	8	9
14. Emotionality	0	1	2	3	4	5	6	7	8	9

4) Informant't Interest in Interview

At Start		At Close
____	1. Lack of interest.	____
____	2. Mild interest.	____
____	3. High interest.	____
____	x. Don't know.	____

5) Informant's Tension Level

At Start		At Close
____	1. Nervous, fidgety.	____
____	2. Sporadic nervousness.	____
____	3. Mostly relaxed.	____
____	x. Don't know.	____

6) Distractions During Interview

____ 1. Much distraction (other poople, TV)
____ 2. Some or occasional distraction
____ 3. No distractions (ideal interview situation)
____ x. Don't know

7) Attitude Toward Interview

____ 1. Hostile
____ 2. Suspicious, guarded
____ 3. Friendly
____ 4. Solicitous
____ x. don't know

8) Alertness and Estimated Intelligence

____ 1. Dull, uncomprehending.
____ 2. Slow, needs explaining.
____ 3. Average intelligence.
____ 4. Above average intelligence and quick.
____ x. Don't know.

9) Appearance and Habits

____ 1. Inappropriate, sloppy.
____ 2. Somewhat untidy.
____ 3. Casual, neat.
____ 4. Overly neat, fastidious.
____ x. Don't know.

INFORMANT_____
(If not patient, relation to patient)

INTERVIEWER_____

VITA

Jan E. Puckett Grisham

Candidate for the Degree of

Master of Science

Thesis: A STUDY OF INSTRUMENTAL PERFORMANCE LEVELS OF FORMER MENTAL PATIENTS IN RELATION TO PERCEIVED EXPECTATIONS OF SIGNIFICANT OTHERS

Major Field: Sociology

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